Exhibit 283

Evolution of the Blues - An Emerging Concept
An Overview 10/79

I. Evolution Towards the Prepayment Concept

A. Medical/Economic Scenario - 1900±

1. Medical/Surgical technology was expanding at a rapid pace. (A condition that continues today.)

2. Doctors and hospital could do more, but it cost more. Doctors "bag" has expanded-Doctors office today has better equipment than the best hosptial had 100 years ago.

3. Society began to expect more from the medical community. Fear was replaced with confidence and high expectations. (2,000 B.C. if a doctor did not cure you he was put to death.) Concept that "health care was a right" began to emerge. (This expectation move fully developed in the 1950's and 1960's and continues today as the fundamental motivation towards universal coverage and NHI.)

4. Urbanization of the society brought people closer to medical facilities and increased utilization. (Reference Nevada's low utilization.)

-Hill/Burton expanded hospitals (Gov't Policy)
-B/C and B/S facilitated financing
-Medicare/Medicaid increased demand

a. Doctors and hospitals found it difficult to collect from the sick or injured. This weakness in the "postpayment financing" mechanism reached its peak during the great Depression. People were deferring health care until it was too late because they could not pay.

B. Community leaders, employers and the medical community approached the insurance industry to provide a financing mechanism for prepayment of health care.

1. The concept that health was not an insurable risk was prevalent.

2. Group insurance principles were not developed (first group life insurance policy issued to Montgomery Wards employees through Equitable in 1912).

3. Doctors were also reluctant to some degree because of fear that a third party financing arrangement might interfere with the Doctor/Patient relationship.

II. Development of the Plans-A Unique National Resource

A. Enter the Blues - Something had to be done (Depression)

1. Community pool concept underwritten by participating doctors and hospitals.

2. HMO Medical/Service Bureau type organization began organizing in the logging camps of the Pacific Northwest. Employees hired doctors to serve employees for a specified monthly fee.

a. Later HMO except was expanded to a community wide basis with fees for services and free choice of physicians and facilities.

3. Plans have the following special characteristics

a. Community sponsored not-for-profit organization (Easy to make profits in health through risk selection)

b. Special enabling legislation - Permitting operation, eliminating taxes and imposing regulation.

c. Provider support and participation - Including assumption of underwriting risk - Accept Plan payment as payment in full

d. Community rated programs to facilitate health care financing to the largest segment of the population possible.

e. Broad Coverage that protects

f. Service Benefit Principle - First Dollar Coverage

g. Special problems - Coverage for the poor and aged.

4. Blue Shield - Medical Coverage (the doctors Plan)

a. Plans first sponsored by county medical societies in Washington and Oregon in 1920's led by the formation of Pierce County Medical in Tacoma, Washington in 1913. May be considered the first Blue Shield Plan. Doctors underwrote the Plan - fee schedule.

b. First statewide coverage in 1939 - California Physicians Service. (First Plan with official Blue Shield concept.) Service/Benefits concept delivered through fee schedule with income limitation/support form the state medical/ society.

i. Sponsored by California Medical Association.
ii. Offered comprehensive medical services at $1.70/month.
iii. Scales of fees and premiums were increased until fund was self supporting and physicians were satisfied with income received. (Doctors underwrote the program.)

c. Additional plan started in Michigan in 1939. In 1940, plans started in Buffalo (Got Blue Shield name) and Utica, New York as well as in Pennsylvania and North Carolina.

d. Blue Shield enrollment expanded more slowly due to magnitude of costs. (Now Dental, Drug, Vision, etc.)

	Blue Cross	Blue Shield
1948	30,498	9,934
1955	47,832	34,314
1960	56,063	44,492
1966	63,713	54,627
1978	83,256	70,127

-We called it enrollment not marketing!

e. Factors contributing to expansion

i. Social demand for sophisticated medical services and a reliable method to finance them.
ii. Depression
iii. Wage and price controls during W/W II
iv. Expansion of union bargaining strength 1940's and 1950's
v. Order of expansion

-Hospital Coverage
-Medical/Surgical Coverage
-Dental
-Drug-Out-of-hospital
-Psychiatric
-Vision and Hearing

5. Blue Cross - Hospital Coverage (The hospital Plan)

a. Modern hospital insurance movement dates from development of Baylor University Hospital in 1929 (Justin Ford Kimball)

i. Motivation of development was severe financial straights of university's hospital and clinic.
ii. Plan developed and offered to teachers group.
iii. Offered 21 days of hospitalization for $.50/month including operating-room use, laboratory service, drugs and dressings.
iv. Other employee groups soon joined Plan.

b. Baylor Plan initiated development of hospital plans in other communities. In the beginning Plan was limited to one hospital - later expanded to the community concept.

c. GHI founded in D.C. 7/1/34 by General Frank T. Hines, later chartered by Congress 8/11/39. First contract provided 21 days of hospitalization @$.75/month (50% increase) in 7/1/34. Later reduced to $.65/month on 12/1/37 since the Plan was making money. Don P. Dolan was the first subscriber to receive benefits under the Plan at Episcopal Ear, Eye, Nose and Throat Hospital in the District. Plan reimbursed hospitals @90% of charges.

6. Plans were non-profit, public service corporations originated and regulated under special enabling legislation.

7. Providers accepted underwritten risk guarantees because something was better than nothing.

8. We had one product at one rate for the entire community.

   a. Our purpose was to facilitate the financing of health care to make health care services available to the largest possible segment of the population at affordable rates.

   b. Emphasis was on employee group benefit concept of financing.

9. We had no special need for sophisticated financial actuarial management systems and controls.

   a. We had no need for cost accountants and little need for financial accountants.

   b. We were the only game in town and we had one product, two at the most.

10. We were growing at an unbelievable rate through expansion of local plans across the nation.

    a. We were developing a concept and building a national system.

11. We were better than McDonalds, Burger King and Wendy's combined.

12. Terms to Note

    a. COB
    b. Community Enrollment

c. Complementary Benefits
d. Fee Schedule
e. First Dollar Coverage
f. Group Conversion
g. Indemnity Benefit
h. Participating Physician
i. Per Diem Payment
j. % of Charges Payment
k. Audit Cost Reimbursement
l. UCR Fees - Mid 60's 1967 - Interim Reciprocity market demand for paid-in full program
m. Service Benefit Contract
n. Enabling Legislation

III. Development of the National Association - Demand for Nationwide Delivery

A. Original purpose of the Association was to promote the development and expansion of Plans.

B. Current purpose is to coordinate national activities and programs, provide leadership and cohesion to the system.

C. Blue Shield Association

1. In 1938, the American Medical Association endorsed principle of "Medical service plans" and set forth guiding principles. CPS found 1939 - one year later - Michigan in 1940 - endorsed service benefits of indemnity concepts (1942).

2. In 1943, the AMA established a council on medical services to act as clearinghouse for information, to conduct studies, and to assist local plans generally. 1944 AMA to employ an expert to help create plans.

3. Council established a set of "Standards for Acceptance" and eventually a "Seal of Approval" for approved plans.

4. In 1946, some of the councils functions were taken over by the Associated Medical Care Plans, Inc., (there were nine Plans with 1 million members) whose name was changed in 1950 to Blue Shield Medical Care Plans, Inc. In 1960, it became the National Association of Blue Shield Plans and in 1977 the Blue Shield Association.

5. Specific membership standards were adopted in 1950.

6. Blue Cross Association

a. In 1933, American Hospital Association began to encourage and aid in the development of plans.

b. In 1936, AHA established the Commission on Hospital Service which eventually became the Blue Cross Association.

Walt McNerney has been President since the early days.

7. HSI/MIA came in the 1950's to provide Major Medical

a. Owned by the Associations and operate in all states
b. Plans could not assume M/M risk
c. Did not want to depart from 1st dollar principle.

-M/M had controversial deductible and coinsurance features

Note:

At one time (1958) BSA, BCA, HSI and MIA and the Illinois Plan were all in the Mandell Building (a converted warehouse). In 1980 BSA, BCA and HSI/MIA will again be in the same building.

8. Enter Competition

a. Health was an Insurable Risk - The Blues Proved It.

Profit oriented insurance companies then realized that certain segments of the population were better health risks than others. - To hell with public service - To hell with competitive efficiency. These vultures were only interested in Profit Maximization. The Experience Rate was born. Our community rate was under attack and in danger. The Blues fought back to retain the cream and protect the concept. Thank God for our efficiency, our not-for-profit public service spirit, our special enabling legislation and our special relationships with providers.

b. We continued to expand (1950-1960's) - We became a dominant National Force in Health Care Financing. We became a National Resource - a real asset to effective, efficient Health Care Financing.

c. Our Business continued to become more complex and competitive. The public continued to prefer Blue Cross and Blue Shield and began to demand that we make available our programs and services on a national basis in a manner as uniform as possible. We were faced with a new challenge. Our strengths and development was based on the success and strengths of local autonomous plans. Our market was demanding national products and services. The challenge was to meet this demand, capitalize on its opportunities to further achieve our public service goals and retain our local autonomy - indeed our proven formula for success.

d. Enrollment Composition - Membership (1978)

Experience Rated Group	35,247	42%
National Accounts	16,126	20%
FEP	5,381	7%
E/R		69%
Community Rated Group	10,435	13.0%
Student	411	.5%
HMO	493	.5%
Group Conversion	2,920	3.0%
Direct Pay	3,185	4.0%
MEC - Group	3,165	3.0%
- Direct Pay	5,673	7.0%
		31.0%
	83,216	100%

IV. Expanding Business Segments - Age of Complexity and Competition

Enter Sophisticated Management Talent - Emphasis Financial/Actuarial Talents - Financial and Cost Accounting. (Certified Health Consultant Program)

A. Our market continued to become more complex, competitive and program oriented. We were developing financial practices to deliver efficient health care financing both at the local level and as a system.

Plan local strengths were the key to our growth - national market demanded national coordination and leadership.

1. Direct Pay Basis Programs - Blue Cross/Blue Shield - Generally community rated - with regulatory approvals necessary in many cases.

2. Local Group Basic Programs - Represents a combination of experience rated, community rated and cost plus group accounts of all sizes and benefit structures. Normally represents the bulk of local Plan business and may require regulatory approval of rates and formulas.

3. National Accounts - During the mid-1940's the auto accounts and others (Steel, Bell, etc. negotiated contracts with Plans individually. In 1951 the first national agreement was implemented with the autos. Now all Plans participate in the national "Equalized Accounts" program. These are primarily (experience rated) underwritten accounts with sharing of gains and losses by participating Plans. Agreements betweeen Plans provide for recovery of reasonable actual administrative costs at unit cost rates for each Plan which are based on actual filed National Account costs.

4. Inter Plan Bank/Reciprocity (1971) for UCR -

Bank became operational 5/1/49 with 48% of the Plans electing to participate - become a requirement 10/1/55. Reciprocity developed in 1967 to facilitate UCR payments which were replacing fee schedule arrangements. These programs to serve local Plan subscribers on a Nationwide Basis. Provision is made for recovery of actual costs.

Providers and Plans are able to maintain same relationships in serving out of area subscribers. Gives national scope to B/C and B/S.

Birmingham City employees struck to keep this feature.

5. Champus - Originally began in 1956 - Called Medicare.

Name changed in 1966 to Civilian Health and Medical Program of the Uniformed Services.

A service program for military dependents with provision for recovery of actual administrative costs. The Blues were dominant. In recent times O'Champus management put administrative cost reduction goals ahead of program service requirements and awarded contracts to the lowest bidders without regard for proven delivery capabilities. Resulting chaos, complaints and confusion for non-performance by non-Blues contractors led to the recent ouster of Joe Rhea and Lorraine Carpenter from O'Champus hopefully reversing the recent bankrupt policies.

6. FEP - 1960 - Underwritten on a one way street basis with a provision to recover actual program administrative costs not to exceed 5.5%, then 4.5%, now 5.5% at Earned Subscription Revenue (then the national average for Health Benefit Plans), we weren't even close. Complexity of benefits and other administrative demands have changed this to the point where today it is difficult to stay within the 5%, now 5.5% limit. Efficiency and effectiveness are crucial. A unique National Contract to be administered by all Plans through the association - $1.8 billion revenue.

-Now a national HMO network is being developed to offer this choice to FEP subscribers.

7. Medicare A - 1966 and thanks to a special surprise, last minute move by Wilbur Mills (prior to his meeting with Fannie Fox - the Argentine Firecracker), Medicare B. These were to be serviced programs with provisions for recovery of actual administrative costs. The Blues were dominant.

   a. Legislative battle extended over 20 years of debate. (Roosevelt, Truman, Eisenhower, Kennedy, Johnson).

   b. 1964 Election was crucial with Johnson's victory over Goldwater. Medicare was a leading part of the Great Society program. Goldwater was strongly opposed. (Marvin Kitman view toward War on Poverty)

   c. B/C and B/S, AHA and AMA were initially against the program. B/C and B/S views changed in recognition of the special problems of providing financing for the aged and poor. Especially with the attack on the Community Rate - AMA held to the end.

   d. Johnson wanted a hospital program financial through Social Security taxes.

e. Republicans (John Byrnes of Wisconsin) wanted a hospital, M/S program financial outside of SS taxes with governmental subsidies to supplement private financing.

f. The AMA offered "Eldercare" similar to the Byrnes proposal.

g. Louis Harris poll indicated Americans expected Medicare to be comprehensive.

h. Wilbor Mills ingenious surprise

- Part A - Hospital Financial compulsory program through mandatory S.S. taxes (Johnson model).

- Part B - Medical/Surgical Voluntary supplemental insurance program financed in equal amounts from insured premiums and matching federal contributions. (Byrnes, AMA model)

  Fortune called it the "Elder-Medi-Better Care" program.

  Johnson signed P.L. 89-97 on 7/30/65 to create Medicare.

- Blues Administration - Since the Blues only desire was to facilitate health care financing we agreed to act as intermediaries (nominated by providers) and carriers (named by HEW) on a cost reimbursement basis.

i. Medicare-Deductibles and Coinsurance - Opposed to the Blues belief in service benefit - 1st dollar coverage. For cost reasons Part A & B deductibles and coinsurance were set as follows:

	Part A		Part B	
	1966	1980	1966	1980
Deductible*	$40	$180	$50	$60
Co-Insurance			20%	20%
60-90 days	$10@day	$45@day	of Medicare	
90+		$90@day	allowances	
(60 day life time reserve)				

*Equivalent to one days hospital care.

j. Medicare Supplemental - Community Rated - A highly competitive underwritten program developed to fill the gaps left by Medicare - Hence the name Medigap policies.

k. Medicaid - Title XIX-1966 - (A step child of Medicare - A sleeper) - Program of Medical Benefits for the poor. The Blues were to have a major role. At state option most of the programs were put on a service basis with provision for recovery at actual administrative costs. However, in at least one state, Texas, the program was on an underwritten basis. All states except Arizona enacted a XIX program. In 1969 the Reno, Nevada Plan was formed with its only line of business the XIX program.

l. ASO Accounts - Serviced accounts where account is entirely at risk. Blue Cross/Blue Shield provides administrative services selected by the account generally at an established retention rate. Involvement with this type of account is discouraged.

m. Comprehensive Major Medical
-Major Medical
-Dental
-Drug, Vision, Hearing
-Prepaid Legal
-HMO's

n. New Experimental Program Demands by Medicare/ Medicaid and others

i. Fixed Price Competitive Bids - Medicare B in Maine, others. Requires estimation of volumes and costs in advance for an extended period. Chance for gain or loss on administration - requires new financial management capabilities.

ii. Fixed Rate - Maryland - Requires estimation of required unit costs over an extended period at varying volume levels.

V. The future challenge - Managerial Leadership and Adaptability Key to Survival and Growth

A. The old days of carriers as a financial conduit between consumers and providers are gone.

B. The public expects comprehensive coverage, at reasonable cost with undue interference in the patient/provider relationship.

C. Service benefit plans have the best opportunuty for meeting this demand for better quality, comprehensive care at a reasonable cost.

D. The future belongs to those who are innovative and create what they have to offer as health care financing and delivery alternatives. The fight will be rugged from here on.

- Must be careful in provider incentive arrangements as workmens compensation programs found many years ago "It is cheaper to cut a leg off than to save it".

E. More services are being demanded - but costs cannot continue to escalate at present rates. (See chart for GNP consumption increase.)

TABLE XI National Health Expenditures: Aggregate and Per Capita Amounts and Percent of Gross National Product, Selected Fiscal Years 1929-1976

Fiscal Year	GNP (in billions)	Amount (in millions)	Per Capita	Percent of GNP
1929	$ 101.3	$ 3,589	$ 29.16	3.5
1940	95.4	3,883	28.98	4.1
1950	264.8	12,027	78.35	4.5
1960	498.3	25,856	141.63	5.2
1965	658.0	38,892	197.75	5.9
1970	960.2	69,201	333.57	7.2
1974	1,361.2	106,321	495.01	7.8
1975	1,452.3	122,231	564.35	8.4
1976a	1,611.8	139,312	637.97	8.6
1979				10.0

[a]Preliminary

Source: R.M. Gibson and M.S. Mueller, "National Health Expenditures, FY 1976," Social Security Bulletin, April 1977, p.4.

VI Conclusion

Timely and reliable financial data and leadership capabilities are becoming increasingly important to our continued expansion and/or survival in an increasingly complex and competitive environment. Unlike many years ago, the financial executive now has a vital role in assuring our continued growth and survival in our continuing efforts to provide efficient effective health care financing to the largest possible segment of our population.